EXHIBIT D

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF WEST VIRGINIA
CHARLESTON DIVISION

IN RE: ETHICON, INC. PELVIC REPAIR SYSTEM PRODUCTS LIABILITY LITIGATION	) Master File No. 2:12-MD-02327
THIS DOCUMENT RELATES TO ALL WAVE 4 PLAINTIFFS	) JOSEPH R. GOODWIN U.S. DISTRICT JUDGE

DEPOSITION OF TED M. ROTH, M.D.

(PROLIFT+M)

DEPOSITION OF: TED M. ROTH, M.D., taken before Lynne M. Morrison, Notary Public in and for the State of Maine, pursuant to notice dated March 13, 2017, at Embassy Suites Hotel, 1050 Westbrook Street, Portland, Maine, on March 17, 2017, commencing at 10:02 a.m.

APPEARANCES

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EXHIBITS

*(Exhibits 1 through 5 included in original and copies.)

TRANSCRIPT OF TESTIMONY

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TED M. ROTH, M.D., having been duly sworn by the Notary Public, was deposed and testified as follows:

* * * * *

DIRECT EXAMINATION

BY MR. FAES:

Q. Good morning, Dr. Roth.
A. Good morning.
Q. My name is Andy Faes, and we met yesterday where we talked for about five hours regarding your opinion, general opinions on the TVT and TVT-O devices. Do you remember that?
A. Yes.
Q. And today we're here to talk about your general opinions regarding the Prolift+M device. Is that your understanding?
A. Yes.
Q. As before, as with yesterday, if I ask a question that you don't understand for any reason, please let me know and I'll try to rephrase the question. If you answer the question, I will assume that you understood

the question as asked. Fair enough?
A. Yes.
Q. Doctor, I've handed you four premarked exhibits. The first exhibit is Exhibit No. 1, which is the Notice of Deposition. It's the same notice as yesterday.

Have you brought anything with you today in response to that notice that you didn't already produce yesterday?
A. No.
Q. Oh, and I just wanted to ask you actually one more question. Back up.

Is it your understanding that you're here today -- you're only being offered as an expert this time regarding the Prolift+M device?
A. That's my understanding.

MR. FAES: And I just want to make it clear for the record that we've been told that at this time he's only being offered as a general expert on the Prolift+M device even though his expert report contains information on the Prolift and Gynemesh PS device as well. So if he's declared as a general expert on

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either the Prolift or Gynemesh PS at a later date, we would reserve our rights to take an additional deposition on those two products at that time. Is that your understanding as well?

MS. KATZ GERSTEL: Yes, that's our understanding.

BY MR. FAES:

Q. So what have you brought with you today to this deposition?

A. I brought a copy of my report on Prolift and Prolift+M, which you have, and I brought some selected articles from my reliance list similar to actually the one I brought yesterday but left in my bag.

Q. And yesterday we marked a supplemental reliance list during your TVT and TVT-O deposition. I believe it was Exhibit 3A. Is that your reliance list for your opinions in the Prolift+M case as well?

A. I can't remember what specifically was on the supplemental reliance list, but I think the reliance list is pretty much everything from TVT, TVT-O, Prolift, Prolift+M, Gynemesh PS.

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Q. Is there any literature that you've brought with you today that isn't listed on the exhibit that we marked yesterday as Exhibit 3A which was your supplemental reliance list?

A. This is all part of the reliance list, nothing different than what was on the reliance list.

Q. And does the reliance list we marked yesterday as Exhibit 3A contain a listing of all the materials that you've reviewed and relied upon in forming your opinions regarding the Prolift+M product?

A. Yes.

Q. You brought a report with you today regarding the Prolift+M, and I've also marked a copy of that as Exhibit No. 2. Do you have that in front of you?

A. Yes.

Q. Is that the same report as what you've brought with you today on your own?

A. It appears to be the same report, yes.

Q. And this report is dated January 31, 2017. Is that when you completed and signed it?

A. Yes.

Q. Does this report marked as Exhibit No. 2

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contain all of the opinions that you've reached regarding the Prolift+M in this case?

A. Yes.

Q. Now, this particular report is titled Prolift, Prolift+M and Gynemesh PS; is that correct?

A. It is.

Q. So you've combined three different products into a single report; is that correct?

A. Yes.

Q. Do you have an understanding that the Prolift+M device has a completely different mesh than what is in the Prolift, and it's different than the Gynemesh PS?

A. Yes.

Q. So even though it contains a completely different mesh, you still felt it was appropriate to combine all your opinions regarding these three products into a single report?

A. Yes.

Q. Now, I was going through your report, and I don't see that you mention the Prolift+M specifically until about page 28 of your report. Do you know if that's accurate or

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not?

A. That's where I sort of focus on the Prolift+M in particular.

Q. And I guess I don't want to belabor that point. I guess you do use Prolift+M in one other spot on page 13, but I guess what I'm getting at in my question to you is in pages 1 through 27 when you're repeatedly referring to the Prolift, are you using the Prolift interchangeably with Prolift+M on pages 1 through 27 of your report, or are you specifically referring to the older Prolift device which contains the Gynemesh PS mesh, not the Ultrapro mesh?

A. Ultimately, it depends upon which paragraph you're referring to. For instance, page 11, paragraph marked C, so, for instance, that study is the original Prolift. Complications listed on page 12, again, I think I used the language transvaginal mesh, mesh kits, so that would include both Prolift+M and the original Prolift. Page 13, mesh exposure is a risk of transvaginal mesh, Prolift, Prolift+M, Gynemesh PS. Page 10, Altman's Randomized

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Control Trial was the original Prolift.
You know, um, I mean, I certainly could have submitted three separate reports. I mean, I could have repeated a lot of information in the first part of the report for the original Prolift covering the Prolift+M. I didn't really see a need to separate out the products in a report.
Q. I mean, I guess what I'm getting at, is there any spot in this report where you refer to the Prolift when you are actually referring to the Prolift and the Prolift+M as well, and how would I as a reader who is trying to understand your opinions that you're going to offer in this case know the difference, if that is, indeed, the case?
A. Well, most of my opinions for the Prolift+M, I guess, start on page 28, although some of what I write about in terms of degradation of polypropylene toxicity, because the Prolift+M is also polypropylene, applies to Prolift+M.
The issues with Recall Bias that I discuss on page 20 apply to not only Prolift+M and Prolift but almost all surgical

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procedures. Biocompatibility of Polypropylene mesh, page 21, would apply to the polypropylene that is both in Prolift and Gynemesh PS and Prolift+M. Discussion of infection, page 16, regarding Type I macroporous meshes would apply to both Prolift, Gynemesh and Prolift+M.
So I didn't mean to make it confusing in terms of addressing the individual products. I just tried to because brevity is the soul of wit combine a report for all three products.
Q. And how many -- well, strike that.
When were you first approached to be an expert specifically regarding the Prolift+M product?
A. It was the same time that I was approached to be an expert for TVT, and we chatted about that yesterday. My recollection is I was contacted by Doug DiPaola 2014, 2015ish.
Q. And how many hours would you say you've spent working on your Prolift+M report, and that includes both review of materials and writing the actual report as well as any deposition prep time?

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A. I mean, you have the bill or the accountable hours there. Can I review that?
Q. Sure. And just for the record, you're referring to the exhibit that we marked at yesterday's deposition as Exhibit 1A.
A. So specifically for the Prolift+M reports, although the original report I think that I wrote was actually Prolift and Gynemesh and then I was asked to essentially add Prolift+M to that report, I probably spent, let's see, at least 12.25 hours on the Prolift+M portion of the report. But there was also revisions made to the Prolift, Gynemesh PS part of the report. 15 or 20 hours for the Prolift+M part of the report.
Q. Okay. Now, in your report, you discuss both Gynemesh PS and Prolift. Do you have an understanding that the mesh in the -- that the Gynemesh PS is the same mesh as what is in the Prolift mesh?
A. Yes.
Q. And what is your understanding with regard to the Prolift+M mesh? Do you know if that mesh is used for any other application?

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A. My understanding is that the other name for the Prolift+M, I don't know if it's still marketed as such, is the Ultrapro mesh, and I think that has applications in hernia repair.
Q. So you would agree that the Prolift+M mesh is still available as the Ultrapro mesh for sale to physicians for use in the United States, correct?
A. Um, I'm not too sure. I don't do abdominal hernia repairs, and I haven't investigated whether Ultrapro is still marketed or available.
Q. Okay. In your expert report marked as Exhibit No. 2, you go through various facts and literature and discuss various facts and literature. Did you discuss the facts and literature in your expert report that you felt were the most important to you in drawing your conclusions and making your opinions regarding the Prolift+M device?
A. Yes.
Q. And there are also, as I said, articles cited throughout your report, correct?
A. There is articles cited for Prolift+M, and

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there is articles cited for Prolift and polypropylene, yes.
Q. In terms of your decision-making in writing your report, why did you cite the articles that you did in your report with regard to Prolift+M?
A. Do you want me to go through each article and their merits?
Q. Well, I was more asking a general question of why you chose the articles that you did to discuss in your report.
A. I tried to carefully review the literature. These were, in my opinion, the salient articles on Prolift+M. That's why I chose these articles.
Q. Would you agree that they're the articles -- strike that.
You'd agree that the articles that you cited -- specifically cited in your report is not a comprehensive listing of all the available medical literature specifically regarding the Prolift+M, correct?
A. I don't know that I can tell you how many actual articles are out there for Prolift+M.

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Q. Yeah, I understand, Doctor. My question is you would agree that you didn't -- I think that's a fairly non-controversial question. You didn't choose to cite every single article that is available regarding Prolift+M in the body of your report, correct?
A. Yeah, correct.
Q. So you said that you chose what you felt were the most salient ones, right?
A. That's correct.
Q. So my question is what about the articles you chose led you to believe that they were the most salient articles, in your words?
A. So I guess I can ask again, do you want me to go through each one of the articles that I reviewed and describe why I think each one has merit and is salient because it's kind of a broad question?
Each of the articles that I used are certainly different. You have Khandwala's article. That's a prospective cohort, single center. You have Milani. That's a cohort study but multiple centers also with one year follow-up as well Khandwala's study.

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Then there was also a reference made to an article on the hernia literature about heavyweight, mid-weight, lightweight polypropylene meshes. Then there was Quemener, which has a slightly different study design but also had a follow-up with 20 months with a fairly significant number of patients. Another retrospective cohort study by Lensen looking at both patients with Prolift and Prolift+M combined.
I felt like these were the key articles. I also like the article by Body which looked at sexual function after patients with Prolift and Prolift+M. And, ultimately, you know, because there is not really a lot of randomized control trials of Prolift+M, I did cite one of the meta-analyses or actually multiple meta-analyses, which, again, is the best evidence -- much better evidence for than cohort studies or RCTs.
I don't know if that answers your question.
Q. I think so, Doctor. I've re-marked a copy of your C.V. from yesterday as Exhibit No. 3.

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A. Sure.
Q. If you need to refer back to that, you can. But within your C.V. there is a list of publications. Do any of the publications in your C.V. specifically address the Prolift+M device?
A. No, not specifically, no.
Q. Do any of the publications on your C.V. that you've participated in address the transvaginal mesh technique for the treatment of prolapse?
A. The only publication -- well, I did a book chapter on vaginal stricture after pelvic organ prolapse surgery, and some of that chapter covers mesh revision surgery and those challenges.
Q. Are there any other publications that you've done that specifically address the TVM technique for the treatment of prolapse?
A. No.
Q. Would you agree that the Prolift+M is an alternative surgical procedure for the treatment of prolapse as compared to other techniques that are available to physicians?

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MS. KATZ GERSTEL: Object to form.
A. I mean, it's available in the armamentarium, or it was available in a surgeon's armamentarium for prolapse, so it's an alternate to traditional methods.
BY MR. FAES:
Q. Now, you've used both the Prolift and the Prolift+M in your practice, correct?
A. That's correct.
Q. And you've implanted approximately 160 Prolifts and 80 Prolift+Ms; is that correct?
A. That's about right.
Q. How many -- strike that.
When was the first time that you implanted a Prolift device, the original Prolift?
A. 2005, 2006, maybe.
Q. And when was the first time that you implanted the Prolift+M device?
A. It was probably sometime in 2008, late 2008, I think.
Q. So you believe that you first implanted the Prolift+M device in late 2008?
A. I think so.

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Q. Were you specifically trained on the Prolift+M device, or did you just rely on your previous training on the Prolift device before you implanted that the first time?
A. There was not really significant -- I wouldn't really consider it significant changes to the device. Means of introduction, trocars, essentially it was the same technique. So as far as I know, there wasn't additional or supplemental training offer.
Q. Prior to using the Prolift+M for the first time, did anyone instruct you or inform you that the handling of the mesh could be different?
MS. KATZ GERSTEL: Object to form.
A. Handling of the mesh? I'm not sure what you mean.
BY MR. FAES:
Q. Let me back up. First of all, you've held both the Prolift mesh and the Prolift+M mesh in your hands prior to and during surgery, right?
A. Yes.
Q. Does the mesh feel different in your hands

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prior to and during surgery between the Prolift and the Prolift+M mesh?
MS. KATZ GERSTEL: Object to form.
A. Yes.
BY MR. FAES:
Q. Do you have to -- do you feel like you have to handle the mesh any differently during implantation of the device?
A. I think what you mean is how you tension the mesh or how you place the mesh, is that different during the procedure because of how the meshes feel in your hand?
Q. Yes.
A. Yes.
Q. How is it different?
A. So the Prolift+M at least, you know, in your hand is a little stiffer than the original Prolift, and I would attribute that to the weight of the mesh because of the combination of the polypropylene and the Monocryl, the dissolvable material.
Q. Did any -- strike that.
Do you feel like you have to handle the Prolift+M mesh differently when you place it

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in order for the mesh to be placed successfully compared to the Prolift procedure?
MS. KATZ GERSTEL: Object to form.
A. No, I don't think that the technique was all that different. It was you still have to place the mesh in a, as they say, a tension-free fashion, lay the mesh in flat, you know, secure the mesh, or at least my inclination was to secure the mesh at the bladder neck and also secure the mesh at the cervix, really not all that significant.
BY MR. FAES:
Q. When you first started using the Prolift+M mesh in 2008, did you have an understanding at that time that you were one of the first physicians in the United States to start using that device?
A. I think I was one of the first physicians to use the original Prolift, too. Yeah, I think that the Prolift+M was cleared by the FDA sometime in maybe May of 2008. But, like I said, to the best of my recollection, I probably used it in late 2008 or 2009.

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Q. Did you have an understanding when you were using the Prolift+M in 2008 and 2009 that Ethicon and Johnson & Johnson hadn't made the Prolift+M available to all surgeons; they kind of just made it available to a limited number of surgeons? Did you have that understanding or not?
A. I don't know that that was made clear to me.
Q. Do you know whether or not that's true today?
A. I haven't investigated who got their hands on Prolift+M sooner than other folks.
Q. So in forming your opinions in this case, you don't know when Ethicon and Johnson & Johnson did what they called a full launch of the Prolift+M device, meaning they made it generally available to all physicians as opposed to just selected physicians?
A. I don't know.
Q. And you were a preceptor for Prolift+M, correct?
A. I was a preceptor or proctor for both Prolift and Prolift+M.
Q. Can you recall -- strike that.
When was the first time that you did a

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proctoring or preceptoring event specifically for the Prolift+M device, not the Prolift device?
A. I have no recollection.
Q. Did there come a time when Ethicon and Johnson & Johnson informed you as a proctor or preceptor that if you were going to proctor or preceptor the Prolift device that you needed to be able and willing to proctor or preceptor the Prolift+M device as well?
A. I'm sorry, could you repeat that?
Q. Yeah, maybe I can make it a little bit simpler.
Did anyone at Ethicon and Johnson & Johnson ever tell you at some point that if you were going to be a -- continue to be a proctor or preceptor for the original Prolift device that you needed to be willing and able to proctor or be a preceptor for the Prolift+M device as well?
MS. KATZ GERSTEL: Object to form.
A. I don't have any recollection of that.
BY MR. FAES:
Q. If that was indeed the case that you were told

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that, do you feel that would be an appropriate action by Ethicon and Johnson & Johnson?
MS. KATZ GERSTEL: Object to form.
A. I don't know what you mean by appropriate. You know, I didn't have qualms about training people on Prolift+M or training them on the original Prolift.
Q. So you don't think it would be inappropriate for a medical device company to say if you're going to continue to be a teacher for device A such as the Prolift, you also need to be willing and able to be a teacher on device B, the Prolift+M, whether or not you're comfortable implanting that device or not?
MS. KATZ GERSTEL: Object to form.
BY MR. FAES:
Q. Do you think that's appropriate or not?
A. I don't know that I'm in a position to judge what's appropriate for a device company since I didn't work for or at that level in a device company.
Q. Well, what about as a physician, as a physician you were told that in order to continue teaching for a particular device that

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you also needed to be able to teach on a similar but different device regardless of whether or not you were comfortable implanting that device yourself regardless of whether or not that was your device of choice?
MS. KATZ GERSTEL: Object to form.
A. This is kind of hypothetical. I was comfortable with the original Prolift and comfortable with Prolift+M. I don't think that I was ever asked to or put in a situation where, you know, I had to be able to train people on both or not at all.
BY MR. FAES:
Q. Yeah. And it is hypothetical, and hypothetical questions are allowed. So hypothetically, if you were not comfortable with the second device that the company told you -- a company told you that you needed to be willing to teach even though you weren't comfortable implanting that device yourself or recommending it, do you think that would be appropriate?
MS. KATZ GERSTEL: Object to form.
A. I don't know because I was comfortable with

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both devices. I don't know that I have an opinion about that.
BY MR. FAES:
Q. So you don't have an opinion as a physician one way or the other of whether it would be appropriate or inappropriate for a device company to tell you that you had to be willing to teach on a similar but different device to a device that you were comfortable implanting regardless of whether or not you were comfortable with the second device?
MS. KATZ GERSTEL: Objection. Asked and answered.
A. Again, I was comfortable with both devices. I don't know how to answer your question.
BY MR. FAES:
Q. Okay.
A. Sorry.
Q. So when you began to start -- let me back up.
When was the last time that you implanted a Prolift, the traditional Prolift device?
A. I don't recall. I have a better recollection of when I probably implanted the last Prolift+M. I can give you that information.

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Q. So that's going to be my next question, but before I move on to that, is the answer to my question of when you last implanted a traditional Prolift device is that you don't know?
A. I don't know.
Q. And when was the last time that you implanted a Prolift+M device?
A. It was spring or summer of 2011.
Q. And you would agree that you haven't had -- one of the reasons that you haven't implanted a mesh kit for the treatment of pelvic organ prolapse since approximately July of 2011 is because you haven't had a patient who has wanted one since then, correct?
MS. KATZ GERSTEL: Object to form.
A. I think there are a few reasons why I haven't done a transvaginal mesh kit since that time. One reason is the Prolift products were removed from the marketplace and no longer available. Number two, in counseling patients about other mesh products available, a lot of them were peppered by TV advertising about litigation, you know, for mesh.

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So to answer your question, no, I have not had a patient wanting a mesh kit since 2011.
BY MR. FAES:
Q. And specifically since July of 2011, correct?
A. Thereabouts.
Q. When you began to use the Prolift+M device in the latter half of 2008, did you continue to use the original Prolift device, or did you completely switch over to the Prolift+M device?
A. I don't have a great recollection of sort of what we did. I think there were probably a number of Prolifts, the original Prolifts that were stocked at the hospital, and I think that we continued to use a combination of Prolift+M and the original Prolift. And then once I started seeing patients back post-operatively with the Prolift+M, I think that we stopped ordering the original Prolift and continued with the Prolift+M.
Q. So you would agree that at a certain point the Prolift+M device became your kit of choice for the treatment of pelvic organ prolapse over

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the original Prolift kit; is that accurate?
A. Yes.
Q. And why is that?
A. Um, well, I guess I like the idea of the hybrid material. I like the idea of the increase in the pore size. The way I sort of thought about the Prolift+M was that once the absorbable Monocryl material went away, you were left with an lacier framework, if you will, of the polypropylene.
The idea that using, you know, less mesh and having similar outcomes appealed to me most like -- not unlike other things in medicine where, you know, you try to use the least amount of something to achieve, you know, your goal; for instance, the lowest dose of a statin drug to control your cholesterol, et cetera. So that was part of the appeal.
Q. So you testified that one of the reasons why you ultimately switched to the Prolift+M kit as your prolapse kit of choice was that you liked the idea of an increase in pore size; is that accurate?
A. Yes.

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Q. So you would agree that all things being equal, a lighter weight, larger pore mesh may be more beneficial to a patient than a heavier, smaller pore mesh, correct?
MS. KATZ GERSTEL: Objection, mischaracterization.
A. I think in sort of my reading and my takeaway from the literature, you know, I don't think it's so much about it has to do with the weight of the mesh. I think it has to do with the pore size, and it doesn't always -- you know, it's not always an association lighter weight equals larger pores. And so for me, it has to do more with the pore size than the actual weight or density of the mesh material.
BY MR. FAES:
Q. Well, you've agreed that you've already offered the opinion that the Gynemesh PS, which is the same as the Prolift mesh, is already a Type I macroporous mesh, correct?
A. Correct.
Q. And you also believe that the TVT mesh is a Type I macroporous mesh, correct?
A. Mm-hmm.

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Q. So if both of those meshes are already Type I macroporous mesh, why did you like the idea of an increase in pore size with the Ultrapro mesh? Did you believe that that provided your patients with some additional clinical benefit or not?
MS. KATZ GERSTEL: Object to form.
A. You know, again, in my understanding of the literature and healing processes with mesh, at least in, like I said, my understanding, the appealing thing about larger pore size is how the body may react to the larger pores in terms of healing and fibrosis and that you might have a more favorable means of healing with the larger pore size than with smaller pore sizes or with the mesh fibers being closer together.
BY MR. FAES:
Q. And when did you first use Gynemesh PS in your medical practice for the treatment of pelvic organ prolapse?
A. Probably, I mean, I used Gynemesh PS for both vaginal or transvaginal applications as well as sacrocolpopexies. Probably 2005.

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Q. Have you ever used the PROLENE Soft mesh in your medical practice?
A. I don't know that I can make a huge big difference between PROLENE Soft and the Gynemesh PS. I'm more familiar with the labeling of the Gynemesh PS than PROLENE Soft.
Q. Do you know whether there is any difference at all between the Gynemesh PS and the PROLENE Soft mesh?
A. I'm not aware.
Q. Assuming that the Gynemesh PS and the PROLENE Soft mesh are, in fact, exactly the same mesh, do you think it's appropriate for Ethicon and Johnson & Johnson to charge a substantially higher price for the Gynemesh PS mesh than they do for the PROLENE Soft mesh?
MS. KATZ GERSTEL: Objection.
A. You know, I'm not in R & D or marketing. I don't know -- I couldn't tell you what their charges were on these materials when we were using them.
Q. Now, you stated that you've used both the Gynemesh PS in your medical practice both for abdominal sacrocolpopexies and for

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transvaginal mesh applications; is that correct?
A. Yes.
Q. And just for the record, for the rest of the day I will refer to abdominal sacrocolpopexy as ASC because I don't like saying that word.
Do you still use the Gynemesh PS mesh for transvaginal use today?
A. I do not.
Q. When did you stop using it for transvaginal use?
MS. KATZ GERSTEL: Just place an objection. This is a +M deposition.
MR. FAES: Objection is noted.
A. Probably have not used any sort of polypropylene mesh transvaginally placed since 2011.
BY MR. FAES:
Q. And why is that?
A. For the reasons that we discussed earlier, apart from the fact that I don't even know if Gynemesh is still available, number one. And two is the mesh litigation.
Earlier, you asked what my reasons were

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for not using Prolift+M or Prolift, and we discussed the mesh litigation and the availability of Prolift. So in regards to Gynemesh, I don't know if it's still available or being marketed, but the patients, again, are very peppered by the advertisements that they're seeing on TV regarding mesh and mesh litigation.

Q. I guess my reaction, Doctor, which isn't reflected on the record, was I was under the impression that you were still using Gynemesh PS in ASC repairs; is that not accurate?

A. I think you asked about transvaginal application, but for ASCs we're using a different product which is still polypropylene. And part of the theme of yesterday's deposition was cost savings. We're using a product from a different company, Caldera.

Q. And what is that product that you're using?

A. It's a Y-mesh, and it's called IntePro, I-N-T-E-P-R-O.

Q. Actually, I'm not sure if that's right because I'm 99 percent sure that IntePro is made by

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ASTORA Women's Health.

A. What is the name of their mesh?

Q. Well, I mean, just so the record is clear, you might not have the name correct, but you're fairly confident that the Y-mesh that you're using is the Caldera Y-mesh; is that accurate?

A. It's actually the Caldera mesh, just the name escapes me.

Q. And when did you stop using Gynemesh PS for ASC repairs?

A. I don't have a specific recollection. I've used a lot of different meshes for ASC repairs, and a lot of what it sort of boiled down to was cost.

Q. Do you feel that Gynemesh PS is the best mesh available for ASC repairs or not?

A. I'm not aware of a specific study with ASCs that sort of touts what is the best brand of mesh. The majority of us doing ASCs are using some form of polypropylene. I think that most people would agree that polypropylene is the mesh of choice for ASCs. What brand I think has to do with perhaps how you're doing it and what your own experience with that material is

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and handling characteristics and ease of suture placement, things like that.

Q. Well, you'd agree that if you did believe that the Gynemesh PS mesh was the best mesh available for ASC repairs and that it would compromise patient outcomes and safety not to have that mesh available, you would go to your hospital and insist that that be made available for use in your patients; is that accurate?

MS. KATZ GERSTEL: Object to form.

A. Yeah, I try to be a good patient advocate; and so regardless of cost, if I felt like one mesh was better than all the other meshes in regards to safety and rate of exposure and success, then I would go to bat for that mesh. And more importantly, I would go to bat for my patients.

BY MR. FAES:

Q. And you haven't done that with regards to the Gynemesh PS mesh, correct?

A. I have not.

Q. Have you ever used the Gynemesh -- strike that.

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Have you ever used the Prolift+M mesh for an ASC repair? And when I say Prolift+M mesh, I am also referring to the Ultrapro mesh.

A. I have not.

Q. So even though at one time you felt the Ultrapro mesh was your -- strike that.

So even though at one time the Prolift+M mesh, which is also the Ultrapro, was your mesh or kit of choice for the treatment of pelvic organ prolapse, you've never used it in an ASC repair; is that accurate?

A. Yeah, I would say that the hybrid mesh, the Ultrapro mesh, was my mesh of choice for a transvaginal application, but an abdominal sacrocolpopexy is a very different operation than a transvaginal mesh.

Q. So even though an ASC is a very different operation than a transvaginal mesh, you have used the Gynemesh PS mesh in both of those applications, but you haven't used the Ultrapro mesh in both of those applications; is that accurate?

A. That's accurate.

Q. Do you believe that the Ultrapro mesh, which

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is also the Prolift+M mesh, is an appropriate choice for repair of ASC?
A. That I don't know because I don't know that there is specific data to support the use of the so-called hybrid mesh for sacrocolpopexy.
Q. If a physician were to use the Ultrapro mesh in an ASC repair, and again the Ultrapro mesh is the same as the Prolift+M mesh, do you believe that that would be within the standard of care for an ASC repair or not?
MS. KATZ GERSTEL: Object to form.
A. I mean, I've never used a hybrid mesh for an ASC; and, again, that's a vastly different operation than the transvaginal mesh kits. Standard of care, you know, there would have to be some data to support the use of Ultrapro in the abdominal space specifically for ASCs for me to say whether it could become standard of care.
BY MR. FAES:
Q. Have you ever looked or studied that question of whether there is data regarding the Ultrapro mesh for ASC?
A. I am not aware of specific data for Ultrapro

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for ASCs.
Q. My question is have you actually looked for and studied that question?
A. Well, I think I answered that. I'm not aware of any studies with ASC that use Ultrapro. So, yes, I've looked.
Q. You've looked and you couldn't find any?
A. Couldn't find any.
Q. Other than the Prolift and Prolift+M kits, what other kits have you used for the treatment of pelvic organ prolapse?
A. I mean, I've done cadaver labs or participated in cadaver labs for a Boston Sci product and AMS, but the only other mesh kit that I put into a human is the Coloplast Exair.
Q. And how many Exairs did you put into live patients?
A. I think I probably did two.
Q. And why did you stop using the Coloplast Exair products after using it in only two patients?
A. Well, it's not that I sort of was gearing up to use it or stop using it. The rep from Coloplast had a mesh kit which was polypropylene with a similar but slightly

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different method of introduction and trocar retrieval or mesh arm retrieval and wanted me to trial it. So we trialed it on a couple of patients. It handled nicely, but I continued to use Prolift+M at that time.
Q. Are you familiar with the Prosima device at all manufactured by Ethicon and Johnson & Johnson?
A. I am.
Q. Did anyone from Ethicon and Johnson & Johnson ever introduce that product to you or try to get you to use it?
A. Yes.
Q. And why did you choose not to try that device?
A. I think that by the time that J & J introduced Prosima, I think that Prolift+M was already up and running. And I felt like the applications for Prosima were somewhat limited, and I think that Prosima was more geared towards surgeons who were not comfortable with trocar placement, and that was sort of the appeal of Prosima. It was a trocarless mesh device.
Q. So you would agree that one of the potential appeals of the Prosima device was that it was

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trocarless, and it didn't require any trocar passes, correct?
MS. KATZ GERSTEL: Object to form.
A. I think that would appeal to some folks. I think I was certainly comfortable with trocar passage, and I didn't feel a need to adopt Prosima.
BY MR. FAES:
Q. Would you agree that one of the potential benefits of the Prosima device was that it did not require the use of mesh arms like the Prolift+M device?
MS. KATZ GERSTEL: Object to form.
A. I don't know that that was a benefit or a detriment to that product. To be honest with you, I really had very little interest in -- I didn't proctor or teach that product. I never put a single Prosima in a patient.
But in terms of thinking about why mesh kits fail and all of that, on the one hand, I think that not having deep arms and having a trocarless application is maybe both a benefit as well as a detriment to the device. But, again, I don't know the literature well enough

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on Prosima to tell you.
BY MR. FAES:
Q. Would you agree or disagree that the use of mesh arms in a device like the Prolift+M can introduce unique risks to a patient as opposed to a mesh device for pelvic organ prolapse like the Prosima which does not include mesh arms?
MS. KATZ GERSTEL: Object to form.
A. Yeah, there would be risks unique to the passage of those trocars to then retrieve the mesh arms. So, yes, there are unique risks associated with retrieval of the mesh arms.
BY MR. FAES:
Q. Would you agree that when designing a mesh kit like the Prolift+M it would be beneficial to the patient and to patient safety to design the procedure to have as few trocar passes as possible?
A. I don't know that I can say that trocar passes are what is responsible for, you know, issues with Prolift. Prolift is a pretty minimally invasive procedure; and I think that although, as we said yesterday I haven't designed a

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biomedical device or a mesh kit, I think I'm comfortable with the number of trocar passes, and I agree with the design of the device.
Q. So you wouldn't agree that a device that has minimal or less or zero trocar passes is a potential safety benefit to a patient?
A. I think ultimately the question would be, for me, I would have to look at that trocarless device and vet whatever mechanism is being used to potentially keep the mesh in place and/or look at its efficacy and failure rate.
Q. Are you familiar with the AMS Elevate device?
A. Vaguely.
Q. Are you aware that the AMS Elevate device only requires one trocar passage as opposed to the Prolift+M device that requires up to six trocar passes?
A. It's been a while since I've looked at, you know, alternate devices, so I can't tell you that -- I've never used an AMS mesh kit in a human.
Q. So you would agree based on your previous responses that you've never specifically studied the question of whether a device such

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as the Prolift+M, which requires multiple trocar passes, introduces additional risks to the patient because of those trocar passes as opposed to a device that requires less trocar passes like the AMS Elevate or a device that requires zero trocar passes like the Prosima?
MS. KATZ GERSTEL: Object to form.
A. Again, I don't think I can talk about the AMS product because I'm not familiar with their literature. I can't tell you how safe that product was. I don't know what adverse events were associated in the Prosima device. To me, it's sort of hypothetical that less trocar passage would equal more safety. I think I would need to look at a series, papers, and I haven't looked at the Prosima literature or the AMS literature.
BY MR. FAES:
Q. So you would agree then that you've never specifically studied the question or whether or not less trocar passes in a mesh kit such as the Prolift+M would equal more safety, correct?
A. I mean, I don't think there's been a head-to-

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head trial of a multi-trocar transvaginal mesh like Prolift versus a single trocar passage material like the AMS kit. I can tell you that the Prolift+M, despite having multiple trocar passages, I would feel to be safe.
Q. Would you agree that I wouldn't expect you to be able to offer an opinion to a reasonable degree of medical certainty of whether or not if the Prolift+M kit had been designed with less trocar passes than it currently has whether or not that would be safer, more safe or less safe for a patient; is that accurate?
MS. KATZ GERSTEL: Objection, hypothetical.
A. I mean, it's a hypothetical question. You know, the French mesh group designed the device with, you know, two trocar passages on either side for the anterior and one on either side for the posterior. I don't know if less trocar passages would equal greater safety.
And the other question would be for me is how you define safety. What adverse event are we looking to decrease with less trocar passage? That would be my question.

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MS. KATZ GERSTEL: Can we take a bathroom break?
MR. FAES: Sure. I actually need one, too, but I wasn't going to be the one to cry uncle.
(A break was taken.)
BY MR. FAES:
Q. Doctor, we're back on the record after a short break. Are you ready to proceed?
A. Sure.
Q. We may have talked about this some yesterday, but how many Prolift or Prolift+M meshes have you either excised or revised in the course of your career?
A. Today you asked Prolift and Prolift+M. Yesterday I think we discussed only slings.
Q. So my question is, just so it's clear for the record, how many Prolift or Prolift+M meshes have you excised or revised during the course of your career?
A. I mean, I've probably done 60 mesh excisions or revisions; and of those, maybe two-thirds were Prolift. So maybe 40 out of the 60.
Q. When you say 40, do you mean 40 Prolift or

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Prolift+M, or do you mean 40 just Prolift?
A. I don't have a specific breakdown of how many of the 40 were Prolift and how many were +M.
Q. But in your mind, the 40 includes Prolift and Prolift+M, right?
A. I would group them together, yes.
Q. When you say 40 out of the 60, what is the 60 referring to? Is that the number of excisions or revisions of pelvic organ prolapse mesh kits that you've revised in the course of your career, or is that something else?
A. The 60 would include mesh from sacrocolpopexies and mesh from other manufacturer's kits.
Q. So in about 240 cases you've put in a Prolift or Prolift+M, and in about 40 cases you've removed or excised a Prolift or Prolift+M mesh, correct?
A. I mean, the majority of those patients who had a mesh revision or excision were not patients that I implanted. But your numbers are correct.
Q. Do you intend to offer any opinions in this case regarding specifically any complication

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rates or efficacy rates regarding the Prolift+M in your own patients?
A. Yes.
Q. And what is that opinion?
A. I don't know that we specifically put my numbers in the Prolift+M section of my report; but I would say that my rate of exposure, I mean, it's kind of broad, and it's hard for me to sort of single out Prolift+M from the original Prolift. But I would say that my rate of exposure was probably anywhere from eight to 15 percent, at least.
And when I've seen patients back for a Prolift+M, and I continue to see some of these patients, I have not seen anyone come back in symptomatic from a recurrent prolapse. But, then again, you know, maybe we haven't followed them out long enough, as time will tell.
Q. So you believe that your rate of exposure with the Prolift+M specifically is somewhere between eight and 15 percent; is that accurate?
A. Yes.

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Q. And how many patients is that based on?
A. Again, it's hard for me to tease out the Prolift+M from the original Prolift kits. And I would also say that my exposure rate decreased in the time that I started with the original Prolift to when I ended with Prolift+M.
So, you know, like I said, it's hard for me to sort of pull out just what my rate of exposure was for the Prolift+M patients. It all -- and I don't think that I saw much of a difference in rate of exposure between the original Prolift and the Prolift+M, but I think that over time my exposure rates decreased. I think that's more to changes in technique and other factors.
Q. So the eight to 15 percent exposure rate, you can't be any more specific than that? You just have that range; is that accurate?
A. Yeah, eight to 15 percent. I know it's kind of a broad range.
Q. Would you agree that your opinions regarding your own personal experience with your patients regarding the Prolift+M is not based

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upon any formal analysis where you determined the exact number of patients, the number of patients that were lost to follow-up or any standardized evaluation protocol, correct?

MS. KATZ GERSTEL: Object to form.

A. Yeah, I haven't done a retrospective cohort analysis of my Prolift patients where I formally looked at it, but I feel like my mesh exposure rate is anywhere from eight to 15 percent.

BY MR. FAES:

Q. In your expert report starting on page 17, you discuss mesh shrinkage, and you state that all experienced surgeons should know scar tissue can contract and, therefore, such contraction is expected. However, contraction of Gynemesh PS and macroporous polypropylene mesh itself has not been demonstrated. Do you see that?

A. Yes.

Q. Is that an opinion you intend to offer regarding the Prolift+M or Ultrapro mesh?

A. Yes.

Q. So you believe that contraction of the Ultrapro or Prolift+M mesh has not been

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demonstrated?

A. As far as I know, in regards to my own patients and my review of the literature, I haven't seen a well-designed description of mesh shrinkage or contraction for the Prolift+M.

Q. So do you agree or disagree that mesh contraction or shrinkage is a risk of transvaginal POP repair with mesh that has been reported in the published scientific literature?

MS. KATZ GERSTEL: Object to form.

A. I guess, you know, in my read of some of the literature describing mesh shrinkage slash contracture, I've had an issue sort of figuring out how they define or qualify or stage what they mean by mesh shrinkage and contracture. I think that part of, you know, physiological healing of a wound is that you have some mesh -- you have some wound contracture, but I haven't seen a convincing paper to say that there is such a thing. In fact, I think that we have a decent paper by Dietz at least in patients that he followed

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with the AMS kit that he didn't find mesh contracture or shrinkage. In fact, I think he found an increase in total vaginal length, which would be the opposite of what you would get with mesh shrinkage or contracture.

BY MR. FAES:

Q. So I'm not sure that I got an answer to my question that I understood. Are you saying that you agree with that statement, you disagree with it, or you can't answer it yes or no?

A. Like I said, I think it's hard to say that there is mesh shrinkage when I don't know that we've defined or been able to sort of gauge or qualify what that means, you know. I've read -- I probably have the article here. I'm not as organized as you guys with your binders.

So there is an article, and I can't remember if we discussed in the report although I sort of alluded to it, even Ben Feiner and Chris Maher's article, Vaginal Mesh Contraction, I don't think that they really were able to define or quantify mesh shrinkage or contracture in that article.

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So I don't know that I believe that mesh contracture or shrinkage happens.

Q. Okay. So if the FDA concluded that mesh contracture does happen and has been reported in the scientific sign literature, you would disagree with the FDA?

A. I think I would need to look at whatever papers the FDA has reviewed that have reported mesh contracture and sort of see how those authors defined mesh contracture or shrinkage. Clinically, I haven't found that in the case of TVTs, for instance, which is, you know, mesh, that there is any sort of mesh shrinkage. I think if there were mesh shrinkage or contracture that over time if this is a process that occurs over time that we would see patients coming in with urinary retention, more issues with urgency and LUTS symptoms. I haven't found that patients have had loss of vaginal length over time.

In the patients with Prolift that I've seen, I haven't seen that they have developed more urgency or overactive bladder over time related to mesh shrinking or contracting, so I

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haven't seen it in my practice.
Q. So just to be clear, you do not believe that mesh contracture occurs with the Prolift+M?
A. Correct.
Q. Can I have you look at the Prolift+M IFU that is marked as an exhibit in front of you, and specifically I want to have you look at the adverse reaction section on page number two. And if you look under adverse reactions, the first bullet point one of the adverse reactions listed is contracture. Do you see that?
A. I'm sorry, under adverse reactions?
Q. Yes, it's in the last line of the first bullet point, fistula formation, contracture, scarring, mesh exposure, erosion or extrusion?
A. Mm-hmm.
Q. So since you believe that mesh contracture does not occur, do you believe that Ethicon and Johnson & Johnson has provided inaccurate information in their Prolift+M IFU?
MS. KATZ GERSTEL: Objection, mischaracterization.
A. I guess, you know, the language that I would

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sort of for me at least is that that sentence starts off with potential adverse reactions, so that's how I would sort of qualify contracture is that it's a potential adverse reaction. I don't know that I can say more about it than that. But, you know, J & J has it in their IFU that it's a potential reaction.
BY MR. FAES:
Q. Have you ever seen anything from any memorandums or findings from Ethicon's own medical director stating that they believe polypropylene mesh contracts 30 to 50 percent as a rule of thumb?
MS. KATZ GERSTEL: Objection.
A. I haven't seen those communications.
BY MR. FAES:
Q. If that is something Ethicon believed regarding their polypropylene meshes for the treatment of pelvic organ prolapse as early as 2002, would that affect any of the opinions that you're offering in this case regarding the Prolift+M?
MS. KATZ GERSTEL: Objection.

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A. I guess what I would have to know is whether, as you say, if there is a 30 to 50 percent contraction, does that -- how is that realized and does that mean -- how does that affect clinical outcomes. Just to say that there is, you know, 30 to 50 percent contraction of the mesh, I guess I would need to know is, number one, how did they document that. Number two, is it clinically relevant and what does that lead to.
BY MR. FAES:
Q. Let me ask you this, Doctor. Do you believe that a potential adverse reaction of the Prolift mesh is that excessive contraction or shrinkage of the tissue surrounding the mesh, vaginal scarring, tightening and/or shortening may occur?
MS. KATZ GERSTEL: Andy, are you asking about Prolift or Prolift+M? You said Prolift. I just wanted to clarify.
BY MR. FAES:
Q. First, do you believe it's an adverse event of -- if you can answer is it an adverse event of both products, or do you believe it's only an

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adverse event of one or the other?
A. Which particular adverse reactions were you referring to? I'm sorry.
Q. So I'll restate the question. Do you believe that a potential adverse reaction of the Prolift or Prolift+M mesh is that excessive contraction or shrinkage of the tissue surrounding the mesh, vaginal scarring, tightening and/or shortening may occur?
A. I mean, I think those can occur in any reconstructive pelvic floor surgery regardless of whether mesh is used or not.
Q. Do you think that is a reasonable warning to place in the adverse reaction section of the Prolift+M IFU?
MS. KATZ GERSTEL: Object to form.
A. I mean, I think it's a reasonable warning, but I think that those adverse events I think are well known to surgeons operating in this arena, in this space.
BY MR. FAES:
Q. At what time, at any time during when the Prolift+M was marketed and sold or now?
A. Well, I think the majority of the adverse

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events that you listed can occur with any sort of prolapse repair. And so in that regard, I think they're well known to surgeons operating in that arena, and they were certainly known at the time that Prolift was available and had been known prior to, you know, the introduction of mesh kits.

Q. Have you ever engaged in any kind of study or formal analysis of what percentage of surgeons actually know or knew about that particular adverse reaction during the time that the Prolift+M was marketed and sold?

MS. KATZ GERSTEL: Object to form.

A. When you say this particular adverse reaction, you are referring to --

BY MR. FAES:

Q. Excessive contraction or shrinkage of the tissue surrounding the mesh, vaginal scarring, tightening or shortening that may occur?

A. I have not done a poll of other urology, urogyn, GYN surgeons about what they knew or read in the IFU.

Q. So you can't state as you sit here today to a reasonable degree of medical certainty the

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percentage of pelvic floor surgeons who are aware or not aware of that particular risk; is that correct?

MS. KATZ GERSTEL: Object to form.

A. Again, my opinion is that these risks were commonly known for non-mesh procedures as well as mesh procedures. So, I mean, these are the risks of native tissue repairs apart from the use of the word mesh.

Q. My question was a little different than that. My question was can you state to a reasonable degree of medical certainty the percentage of pelvic floor physicians in the United States who knew or didn't know about that particular risk during the time the Prolift+M mesh was sold?

MS. KATZ GERSTEL: Object to form.

A. I can't say what other people what their knowledge base was or what their experiences were. These risks, these adverse reactions were commonly known.

BY MR. FAES:

Q. Do you believe it's -- I take it that you believe it's unnecessary then to put in the

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adverse reactions section of the Prolift or Prolift+M IFU that excessive contraction or shrinkage of the tissue surrounding the mesh, vaginal scarring, tightening and/or shortening may occur?

A. I mean, as we talked about yesterday, I've never written an IFU, and I don't know the specifics of sort of what the FDA might require J&J to put in the IFU, although my recollection is that the FDA was involved with the construction of the IFU for Prolift+M. But, you know, sort of my impression of what needs to be in an IFU is I don't think that you need to put in what are commonly known risks and adverse reactions in the IFU. I think that it's nice that it's there. I don't know that it adds much to, you know, to either encouraging or deterring physicians from using the product. It certainly may help with informed consent for physicians who perhaps are unaware of this, but I offer the opinion that most pelvic surgeons would be aware of these adverse reactions. Common knowledge.

Q. But my question is specifically since you

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think that most physicians are aware and it's common knowledge, do you believe it's unnecessary to include that warning in the IFU for the Prolift or the Prolift+M mesh?

MS. KATZ GERSTEL: Objection. Asked and answered?

A. Again, I don't know that I have an opinion about it either way. I mean, we've already concluded and I've admitted that I've not written or contributed to IFUs.

BY MR. FAES:

Q. Okay. I think you've answered my question then, Doctor. Thank you.

A. Okay.

Q. Do you believe that neuromuscular problems including acute and/or chronic pain in the groin, thigh, leg, pelvic and/or abdominal area is a potential adverse reaction of the Prolift and Prolift+M mesh?

A. I think that the majority of the adverse reactions that you listed are also potential adverse reactions of any prolapse procedure.

Q. So, again, do you have any opinion of whether or not it is necessary or unnecessary to

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include that particular adverse reaction in the IFU for the Prolift+M?
A. Again, I think I'm of the feeling that those were commonly known adverse reactions for any prolapse repair, so these would be common. This would be common knowledge amongst surgeons doing these procedures.
Q. So with regard to that particular adverse reaction or set of adverse reactions, however you want to clarify it, would you agree that you haven't done any kind of formal analysis as to what percentage of pelvic floor physicians in the United States were aware that that was a potential adverse reaction of the Prolift+M during the time it was marketed?
MS. KATZ GERSTEL: Object to form.
A. I haven't done a formal analysis, no.
BY MR. FAES:
Q. And I need to re-ask the question because I'm not sure I got an answer.
My question was specifically -- two questions ago my question was do you believe it is necessary or unnecessary to include a warning in the adverse reaction section of the

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Prolift+M IFU that neuromuscular problems including acute and/or chronic pain in the groin, thigh, leg, pelvic and/or abdominal area may occur?
A. I'm of the opinion that since these are adverse reactions that are commonly known to surgeons operating in this arena and can occur with non-mesh kits that it's not new territory. So, again, I've not written an IFU, but my understanding is that if adverse reactions or risks are common knowledge that the FDA doesn't require a manufacturer to add those things to the IFU. The fact that J&J puts those things into the IFU I think is helpful, and I think -- but I don't know that it adds a whole lot to the IFU.
Q. But my question was specifically can you answer yes or no do you believe it's necessary or unnecessary to -- strike that.
Can you answer yes or no do you believe it's necessary to include those risks in the IFU for the Prolift+M or not?
A. I think if they're commonly known risks associated with any prolapse repair that it's

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not necessary for them to be listed in the IFU.
Q. So if Ethicon and Johnson & Johnson did actually put that risk in one of their IFUs for either the Prolift or Prolift+M mesh, you believe that Ethicon and Johnson & Johnson would be putting unnecessary information in their IFUs; is that correct?
MS. KATZ GERSTEL: Object to form.
A. I think that the information provided here is, as I said, commonly known to surgeons who are operating in this arena. When you say unnecessary to put it in, I don't see the harm in putting it in. I would probably say that the information if it were commonly known to surgeons operating in this arena was put in then it might be not so much unnecessary but perhaps it would be redundant.
BY MR. FAES:
Q. But you would agree that putting that particular risk in the Prolift+M IFU might actually be helpful to some physicians in discussing the risk of their device with the patient and doing informed consent?

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MS. KATZ GERSTEL: Objection.
A. Absolutely.
BY MR. FAES:
Q. And same question with regard to the risk of excessive contraction or shrinkage of the tissue surrounding the mesh. Would you agree with that as well?
MS. KATZ GERSTEL: Objection.
A. In regards to helping counseling patients, absolutely.
BY MR. FAES:
Q. Would it be helpful in reminding doctors that that is a potential risk of the Prolift+M procedure?
MS. KATZ GERSTEL: Objection.
A. I mean, when I was a proctor, I would try to review a lot of this at the cadaver stations and also review these sorts of things when people would come to my hospital and watch surgery. I think more education is better than less education.
BY MR. FAES:
Q. So you would agree then that it might be helpful in reminding the doctor that that

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excessive contraction is a potential risk of the Prolift+M IFU by including it in the adverse reactions section of the IFU, correct?
MS. KATZ GERSTEL: Objection.
A. It can't hurt, so yes.
BY MR. FAES:
Q. Would you agree with me that serious complications associated with surgical mesh for transvaginal repair of pelvic organ prolapse are not rare?
MS. KATZ GERSTEL: Objection.
A. I guess I would need to know how you define a serious adverse event.
BY MR. FAES:
Q. Well, you know the FDA has actually issued a statement stating that serious complications associated with surgical mesh for transvaginal repair of pelvic organ prolapse are not rare, correct?
A. I did read that statement, and one questions how they define serious adverse events.
Q. So can you answer yes or no whether or not you agree or disagree with the FDA statement regarding whether or not serious complications

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with transvaginal mesh for POP are rare?
A. Again, I guess my issue is how the FDA defined serious adverse events. There was a nice poster presentation from a recent AUGS meeting. And, again, what they did was they did a systematic review of the literature. Again, that's different than the MAUDE database, but they did a systematic review of the literature between 2005 and 2016, and they looked at the rate of serious adverse events in the literature. And how they defined serious adverse events was hemorrhage, contraction, mesh infection requiring surgery, injury to visceral structures and fistula. And then they also looked at the rate of serious adverse events of mesh versus traditional repair in ASC.
So based on the review of the literature as opposed to the problematic reporting up to the MAUDE database, I would say that serious adverse events are rare.
Q. So you then would disagree with the statement that serious complications associated with surgical mesh for transvaginal repair of

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pelvic organ prolapse are rare -- are not rare? Sorry.
A. I would. You can have serious adverse events with any procedure for prolapse and/or incontinence. And, again, the issue I have with the FDA warning from 2008 and then the subsequent follow-up in 2011 is that there is no denominator. And it's also very unclear as to what they define as serious adverse events.
My understanding is that the majority of the so-called serious adverse events were related to mesh exposure. And I wouldn't consider exposure of mesh to be a serious adverse event. It's not life threatening. It typically doesn't require rehospitalization. Typically doesn't require re-operation. Exposure of the mesh is oftentimes asymptomatic. Mesh exposure typically doesn't lead to persistent or significant disability, and the interventions to correct a mesh exposure aren't meant to correct disability, aren't going to save or decrease the rate of rehospitalization and/or prevent a life-threatening condition.

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Q. Would you agree or disagree that mesh erosion can require multiple surgeries to repair and can be debilitating in someone?
MS. KATZ GERSTEL: Object to form.
A. When you say debilitating, are you referring to the surgery to remove the mesh, or are you referring to the mesh exposure itself as debilitating?
BY MR. FAES:
Q. I'm referring to the consequences on the patient's quality of life and ability to engage in everyday activities.
A. You know, when I counsel patients about these operations, all prolapse repairs, we talk about quality of life. And these women have pretty significant impaired quality of life from prolapse and from urinary incontinence, and we talk about the potential improvement for quality of life with these operations; but we also talk about how complications from these surgeries that are meant to improve quality of life can lead to worsening of quality of life.
In my experience, yes, sometimes removing

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mesh can require multiple surgeries. I have not seen patients where I've removed mesh left with significant disability after removing mesh, and I have not seen people have inability to perform their activities of daily living because of a mesh complication.
Q. So getting back to my question again, you would agree that mesh erosion from pelvic organ prolapse can require multiple surgeries to repair and can be debilitating in some women. Would you agree or disagree with that?
A. That's possible.
Q. So in cases where the pelvic organ prolapse mesh does require multiple surgeries and ends up being debilitating to women, do you consider that to be a serious adverse event or not, or does it have to be life threatening to you in order to be a serious adverse event?
MS. KATZ GERSTEL: Objection.
A. Well, at least for Dr. Lowman who did this poster at AUGS, she didn't consider however you define life disabling as a serious adverse event. So I guess, you know, I would have to sort of take it on a case-by-case basis to

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sort of, you know, learn more about what that individual patient was experiencing.
My own experience has been that people do quite well with these procedures, and they don't suffer disability or disabling complications like what you're asking about.
BY MR. FAES:
Q. But getting back to my question, do you believe that a mesh erosion that requires multiple surgeries to repair and is debilitating to a woman, can that potentially be a serious adverse event according to your definition, or do you require the event to be life threatening in order for it to be considered a serious adverse event?
MS. KATZ GERSTEL: Object to form.
A. I mean, the reason why we do these operations is to help people, not hurt them. If someone ends up with, you know, a complication, I take it pretty seriously. But most of us, I think, would define a serious adverse event as a life-threatening condition.
BY MR. FAES:
Q. So are you saying that in a case where

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multiple mesh revisions cause debilitating injury to a woman and affect her way of life that you still don't consider that a serious adverse event? Yes or no.
MS. KATZ GERSTEL: Object to form.
A. I guess that would be an adverse event related to the mesh revision surgery as opposed to the mesh being placed. It's hard to answer that question.
BY MR. FAES:
Q. What if the mesh erosion from the POP kit requires multiple surgeries to repair, is debilitating to the woman, and that becomes -- and because of the debilitating injury the woman becomes suicidal and it's then life threatening. Does that then qualify in your mind as a serious adverse event?
MS. KATZ GERSTEL: Object to form.
A. I guess I would really need to learn more about how you define debilitating and, you know, what that means. In my experience, I have not seen patients disabled from either a mesh kit or from surgery to revise a mesh kit or from, you know, the exposures that for the

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most part can be treated nonsurgically and can be treated medically.
BY MR. FAES:
Q. So it's your testimony that you've never seen a woman that has been debilitated from complications from a pelvic organ prolapse mesh?
MS. KATZ GERSTEL: Object to form.
A. I guess I'm still wondering how we're defining debilitating, number one. And I've removed mesh from women who have had pain with intercourse, exposures. I removed sling mesh from the urethra in women who have had urethral injuries. I don't know how we're defining debilitating.
BY MR. FAES:
Q. Doctor, I'm going to hand you what's been marked as Exhibit No. 5 to your deposition. And this is an e-mail dated May 28, 2014, and if I can have you turn actually to the last page which is the beginning of the e-mail string. And you see at the top it states that the product is Gynemesh, and that's the mesh that is used in the Prolift device, correct?

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A. Correct.
Q. And you look under details and it states, It was reported that the patient underwent a surgical procedure on 4/27/05 and TVT and Gynemesh were implanted. It was reported that she experienced pain, erosion of her internal bodily tissue and other injuries following the procedure. It was reported that the patient has undergone multiple surgeries and revisionary procedures. No additional information was provided. Do you see that?
A. I do.
MS. KATZ GERSTEL: Object. This e-mail does not appear to pertain to a Prolift+M.
MR. FAES: Your objection is noted.
BY MR. FAES:
Q. And, again, just to clarify before I go to my next question, your testimony was that you haven't seen a woman debilitated from mesh from pelvic organ prolapse in your experience, correct?
A. Again, I'm not too sure what we mean by debilitated, but I really don't have a clear recollection of anyone being significantly

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debilitated by mesh.
Q. Okay. If you turn to the first page, at the top it states, It was reported that during insertion the patient experienced pain, erosion, extrusion, infection, urinary/bowel problems, recurrence, bleeding, dyspareunia, and vaginal scarring. Then it goes on to state, It was reported that patient underwent mesh excision on 11/11/2005, 1/06/2006, 12/17/2007, 12/01/2008 by Ted M. Roth due to exposure and dyspareunia. Do you see that?
A. I do.
Q. Do you have a recollection upon reviewing this document of any patient that you've treated with pelvic organ prolapse mesh that fits this particular profile?
A. I mean, I have a pretty good memory for a lot of things, but I honestly don't remember doing multiple procedures on one particular person.
Q. So do you have any recollection of any patient that you've treated that had four different revision surgeries of a pelvic organ prolapse mesh product?
A. I don't recall. I don't remember this

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particular patient.
Q. So do you believe that this report is inaccurate?
MS. KATZ GERSTEL: Objection.
A. Well, I believe -- there's my name, and, again, I don't have this person's medical record in front of me to substantiate the procedures that I did on her, and I also don't have the medical record to substantiate what her complaints were. So I don't know what I can say about those.
BY MR. FAES:
Q. Do you believe that a patient who has undergone multiple revisionary procedures including four different mesh excisions across a period of at least three years and is experiencing pain, erosion, bleeding, dyspareunia and vaginal scarring is debilitated or not, or can you not answer from this information?
MS. KATZ GERSTEL: Object to form.
A. I mean, I think I'd have to know how she was before the surgery as well.
You know, there are a lot of people that

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have pain, urinary and bowel problems, bleeding, dyspareunia, scarring before they have surgery. You know, it's hard for me to, you know, answer your question without having all of the information in front of me. We have three sentences.
BY MR. FAES:
Q. So you would agree with me then that a report of a woman who has underwent four different mesh excisions over a period of three years, has pain, erosion, extrusion, infection, urinary/bowel problems, recurrence, bleeding, dyspareunia and vaginal scarring, assuming those are all related to the prolapse mesh, you're still not able to determine whether or not that patient can be considered to have had a debilitating mesh injury?
MS. KATZ GERSTEL: Objection.
A. Not to be difficult, but I would still need to know sort of what her baseline was like prior to, you know, having whatever procedure she had. I would need to know whether she was having pain before the procedure, whether she was having infections or bowel problems, what

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degree prolapse she has because, again, recurrence, assuming that is recurrence of prolapse, you know, there is no single operation that is 100 percent guaranteed to not lead to recurrent prolapse. I would also need to know whether she was having dyspareunia before her procedure or, you know, what vaginal scarring means.

I don't know that I can answer your question without looking at this woman's medical record.

BY MR. FAES:

Q. So you would agree then that the fact that a woman has had four different excisions of a pelvic organ prolapse mesh over a period of three years, it's not reasonable to conclude that that particular patient has likely experienced some pain as a result of those multiple procedures and multiple revisions?

MS. KATZ GERSTEL: Objection, hypothetical.

A. It's hard to know what she has resulted in as a result of those four procedures. My experience with removing mesh and sort of what

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has been put out in the literature is that typically you can resolve a lot of the purported problems of pain with removing the mesh, and albeit it may require more than one operation. But, you know, more times than not, people are left with a reduction in their pain.

BY MR. FAES:

Q. Could you conclude from this report of a person -- strike that.

Could you conclude that if a person has had four separate mesh excisions of a pelvic organ prolapse mesh over a period of four years that that patient more likely than not experienced pain from those multiple extrusions or exposures prior to the mesh revision surgeries?

MS. KATZ GERSTEL: Objection.

A. I mean, there is no way to know, at least looking at this, why she had the mesh excisions four times. Did she have a mesh excision because she was in pain? Did she have a mesh excision because she was bothered by vaginal discharge and bleeding? Did she

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have a mesh excision because her partner felt the mesh when they had coitus? I don't know. I would be happy to review the medical record.

BY MR. FAES:

Q. So all of those potential causes for those excisions of the mesh, you wouldn't consider any of those to be serious adverse events because none of them are life threatening, correct?

MS. KATZ GERSTEL: Objection.

A. The exposure of mesh and the fact that there is a failure rate of mesh and the potential for revision or reoperation, these are the risks of not only mesh surgery but native tissue repairs as well as sacrocolpopexy, which is mesh but not in this space.

BY MR. FAES:

Q. If a patient is unable to -- excuse me, I'm going to start over.

If a patient is unable to comfortably engage in sexual intercourse for the rest of their life as the result of a Prolift+M or other prolapse mesh, would you consider that to be a serious adverse event?

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MS. KATZ GERSTEL: Objection.

A. You know, I mean --

Q. Respectfully, I think, Doctor, this is a yes or no question. So I would ask, if you can, to first answer the question yes, no, or I don't know. Then if you need to add an explanation to the end of that, feel free to do so, but I would like an answer to my question first, please.

MS. KATZ GERSTEL: I object to that and say, Doctor, you should answer the question as you need to in order to be truthful and accurate.

MR. FAES: Respectfully, Counsel, you know that's not the rule. If we need to call Judge Eifert and discuss it, we can. But you know from Judge Eifert the rule is if you're asked a yes or no question, you need to answer the question yes or no or I don't know. And if you need to -- or you can't answer the question yes or no, then if you need to offer an explanation to the end of that to make your answer complete, you can feel free to do so.

But Judge Eifert has ruled on this

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multiple, multiple times on what the rule in these depositions is. So if that is your position, I think we should stop the deposition right now and call Judge Eifert so we can get a responsive answer to the question.

MS. KATZ GERSTEL: I'm going to allow the doctor to answer the question as he needs to to be truthful and accurate. If he can answer with a yes or no, fine.

A. Would you be so kind as to repeat the question at this point?

MR. FAES: Can I have the court reporter please read back the question.

(The pending question was read back by the reporter.)

A. I can't answer that with a yes or no.

BY MR. FAES:

Q. Fair enough, Doctor. Doctor, if a person experiences chronic debilitating pain for the rest of their life as the result of a Prolift+M or other prolapse mesh, would you consider that to be a serious adverse event or not? Yes or no.

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MS. KATZ GERSTEL: Same objection.

A. I can't answer that with a yes or no.

MR. FAES: Doctor, I think I'm about out of time. So if I have any time left, I will reserve the balance of that for redirect. Thank you very much.

CROSS-EXAMINATION

BY MS. KATZ GERSTEL:

Q. Doctor, you were asked a moment ago about Exhibit No. 5 which is an e-mail string; is that correct?

A. Yeah.

Q. And do you see the e-mail string where it starts on the page ending in 0129?

A. Yes.

Q. It's dated Wednesday, October 30, 2013?

A. Correct.

Q. And some of the information in that e-mail is redacted, but do you see in this e-mail where it says initial reporter: attorney?

A. Yes.

Q. Is there any way to verify or validate these claimed injuries which were reported by an attorney just by reading this e-mail?

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A. I think what I said to Mr. Faes was that I can't validate much of anything without looking at this woman's medical record.

Q. Doctor, can pelvic organ prolapse impact a woman's quality of life?

A. Yes.

Q. How?

A. It may cause significant discomfort, pain, back pain, have a decrease in their ability to perform their activities of daily living, dyspareunia, loss of intimacy, feelings of shame and even guilt over that. It can have pretty significant impact on their quality of life.

Q. And do you see patients in your own practice that experience those negative impacts on their quality of life because they suffer pelvic organ prolapse?

A. Yes.

Q. Do you have patients in whom you have implanted Prolift+M that you have followed for years after their surgery?

A. Yes.

Q. Do you actually tend to see your patients in

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whom you implanted a Prolift+M -- strike that. Do the patients in whom you have implanted a Prolift+M for the most part return to you for follow-up care?

MR. FAES: Object to form.

A. Yeah. I mean, that's my impression; but the other side of the coin is if they didn't return to me, I have a pretty good relationship with the other surgeons in the state who might care for those patients, and we keep an open line of communication about patients who don't necessarily return to the implant or the original consulting physician.

BY MS. KATZ GERSTEL:

Q. And for those reasons, do you, therefore -- strike that.

Doctor, for those reasons, are you therefore able to make an assessment of how your patients in whom you have implanted Prolift+M do for years following their surgeries?

A. Yes.

MR. FAES: Object to form.

BY MS. KATZ GERSTEL:

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Q. Are the results that you've had with your patients in whom you've implanted Prolift+M consistent with the medical literature?
A. Yes, that's my feeling.
Q. For most of your patients in whom you've implanted Prolift+M, has Prolift+M improved their quality of life?
MR. FAES: Object to form.
A. Yes.
BY MS. KATZ GERSTEL:
Q. For most of your patients in whom you've implanted Prolift+M, even years after their surgery, are most of them still doing well?
MR. FAES: Object to form.
A. Yes.
Q. Does Prolift+M have advantages that non-mesh pelvic floor repair surgeries don't have?
A. I mean, I feel that there's enough data in the literature to support the use of mesh in the anterior compartment. And I think that the way I sort of think about patient selection is it's not that there is, you know, what are the indications for mesh, but who is the best patient for mesh or who would mesh be best in;

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and I think that there is certainly a role for mesh in patients with recurrent prolapse or advanced stages of prolapse, patients at risk for recurrent prolapse, i.e., folks with levator avulsion.
So, yeah, absolutely there is a role for Prolift+M specifically in the anterior compartment, and there may be a role for mesh in the posterior compartment in patients who have perhaps failed repairs at least based on one study that I reviewed.
Q. Doctor, do you regularly read the peer-reviewed medical literature on transvaginal mesh prolapse repairs?
A. I do.
Q. Do you confer with your colleagues, your surgical colleagues about transvaginal mesh prolapse repairs?
A. I do.
Q. Do you attend medical society conferences -- strike that.
Do you attend medical society conference events on transvaginal mesh prolapse repairs?
A. When you say events, you mean posters and

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presentations at the medical society? Yes, I do.
Q. Do you base your opinions on Prolift+M on the scientific data in the peer-reviewed medical literature and your conversations with your surgical colleagues and the medical society conferences that you attend?
A. I do.
MR. FAES: Object to form.
BY MR. KATZ GERSTEL:
Q. And also on your own practice?
A. I do, yes.
Q. Can serious adverse events result from any pelvic floor repair surgery?
MR. FAES: Object to form.
A. As I've defined serious adverse events, yes. And as what other adverse events were also discussed, as we discussed, can occur with all prolapse repairs.
Q. Including non-mesh repairs?
A. Correct.
Q. Are the majority of the complications you have seen in Prolift+M patients treatable?
A. Yes.

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Q. Are the complications that you've seen in your own practice -- strike that.
Are the kinds of complications after Prolift+M that you've seen in your own practice the same complications that you have seen reported in the literature over time?
MR. FAES: Object to form.
A. Yes.
BY MS. KATZ GERSTEL:
Q. Are the complications that can occur with Prolift+M all complications that can occur with abdominal sacrocolpopexy?
MR. FAES: Object to form.
A. Yes.
BY MS. KATZ GERSTEL:
Q. Are the complications that can occur with Prolift+M all complications that can occur with non-mesh pelvic floor repairs?
A. Yes.
Q. Is exposure or erosion a complication that can happen even with sutures used in non-mesh pelvic floor repairs?
A. Yes.
MR. FAES: Object to form.

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Q. Having implanted some 80 Prolift+M and then followed your patients for years afterwards, are you an expert in how a woman's body reacts to the implantation of mesh with a Prolift+M?
MR. FAES: Object to form.
A. Insomuch as I've been able to follow my patients over years, yes.
BY MS. KATZ GERSTEL:
Q. Having implanted some 80 Prolift+Ms and then followed your patients for years afterward, are you an expert in how the design of Prolift+M minimizes trauma to a woman's body compared to other non-mesh prolapse repairs?
MR. FAES: Object to form.
A. Yes.
BY MS. KATZ GERSTEL:
Q. How does the design of the Prolift+M minimize trauma to a woman's body?
A. I mean, it's a minimally invasive means of providing support to one or multiple compartments of the vagina. Abdominal sacrocolpopexy, I would argue, is at times a maximally invasive means of doing something similar but can't address all of the

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compartment.
So I think in that regard, I think that the Prolift or rather the construction of the Prolift and the application of the Prolift is minimally invasive and provides minimal tissue trauma.
Q. Do the trocars allow for the Prolift+M to be a minimally invasive surgery?
A. Yes.
Q. As an implanter of Prolift+M as well as a surgeon who performs other non-mesh pelvic floor repairs, regularly reads the peer-reviewed medical literature on pelvic floor repairs, attends medical society conferences and confers with colleagues on pelvic floor repairs, Dr. Roth, are you an expert in the warnings surgeons need to have prior to performing the Prolift+M?
MR. FAES: Object to form.
A. Yes.
BY MS. KATZ GERSTEL:
Q. Are experienced pelvic floor surgeons commonly aware of all of the risks of Prolift+M before reading the IFU?

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MR. FAES: Object to form.
A. That's my opinion, yes.
BY MS. KATZ GERSTEL:
Q. How is it that experienced pelvic floor surgeons are knowledgeable of the risks of Prolift+M before they read an IFU?
MR. FAES: Object to form.
A. I think it's a combination of training, and hopefully they also read the peer-reviewed medical literature and that they're experienced with other forms of prolapse repair that have the same warnings and risk of adverse events.
BY MS. KATZ GERSTEL:
Q. In your opinion, does the Prolift+M IFU appropriately warn pelvic floor surgeons of the risk of Prolift+M?
MR. FAES: Object to form.
A. I feel that it does.
MS. KATZ GERSTEL: I think that's all I have.
REDIRECT EXAMINATION
BY MR. FAES:
Q. I just have a couple follow-up questions for

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you, Doctor.
Earlier, I think defense counsel was asking you whether or not the complications for a non-mesh prolapse surgery are all the same for a mesh repair of pelvic organ prolapse surgery, and you answered that all the complications are the same. Do you remember that?
A. I do.
Q. So you don't believe that mesh erosion, exposure, extrusion is a unique risk to pelvic organ prolapse surgery with mesh?
A. Insomuch as, you know, the mesh is a permanent synthetic material, and permanent synthetic materials are used for native tissue repairs, apical vault suspensions, that permanent sutures, which are akin to mesh in that they're nonabsorbable and are used in uterosacral suspensions and sacrospinous ligament fixations, those sutures -- and, actually, again, the sutures that are oftentimes used for the repairs of the anterior or posterior compartment, all of those sutures can erode, poke through the

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vaginal wall much like mesh can.
Q. So you don't think that mesh erosion, exposure, extrusion is a unique risk of pelvic organ prolapse surgery with mesh; is that accurate?
A. Insomuch as patients can have exposures of, like, or permanent suture material, which is not unlike mesh, no, I don't feel it's a unique adverse event.
Q. Earlier, defense counsel was asking you some questions about Exhibit No. 5 and pointed out that that adverse event report was reported by an attorney.
A. Yes.
Q. Do you know whether or not attorneys in all 50 states in the United States have an ethical obligation to tell the truth and not misrepresent the facts of a particular case?
A. I didn't sit for the Bar exam. I don't know what your code of ethics has you do or not do.
Q. Do you know how many formal complaints have been filed with Ethicon and Johnson & Johnson regarding their pelvic mesh implants?
A. I don't know.

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Q. Do you think that would be information that would be useful in forming your opinions regarding whether or not the Ethicon pelvic mesh products are safe and effective?
A. No.
MS. KATZ GERSTEL: Objection.
BY MR. FAES:
Q. Do you know how many formal complaints have been filed against the company specifically with regard to the Prolift+M mesh?
A. No.
Q. You don't think that would be helpful information to have in forming your opinions regarding the safety and efficacy of the Prolift+M mesh?
A. I think you have to evaluate every case individually for the merit behind the case. I mean, I think that people are entitled to complain or blame surgery on anything. It's one of the reasons why we spoke about recall bias in the report. I haven't had a chance to review a lot of cases in my time as an expert, but so far a lot of the cases that I've reviewed the purported complications are not

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so much related to the mesh themselves but to mismanagement by the patient's providers.
Q. So you don't think that the percentage of patients who have filed a formal complaint to the company regarding the Prolift+M is a potential indicator of patient satisfaction or lack of patient satisfaction?
MS. KATZ GERSTEL: Objection.
A. I mean, I think we have good medical literature to support patient satisfaction with Prolift, at least specific on the original Prolift. I don't know that I would be able to opine about patient satisfaction just merely based on the number of complaints to the company.
BY MR. FAES:
Q. And earlier defense counsel was asking you questions about patients that you have implanted with Prolift+M and their follow-up care. Do you remember that?
A. Yes.
Q. Have you done any kind of formal analysis asking patients if they have gone and seen other doctors for problems or follow-up care

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with their Prolift+M devices?
A. I've not done a formal analysis, no.
Q. So if another -- if one of your patients implanted with Prolift+M went to another doctor, and that doctor didn't tell you about it or was out of your area, you would have no way of knowing whether or not that patient went to another doctor for treatment of a complication with the Prolift+M, right?
A. Well, luckily, I have a good relationship with the other three or four docs in the state that do what I do, and we keep an open line of communication. We sort of have this unwritten agreement to let each other know about each other's patients that perhaps don't follow up.
It doesn't happen that often, and I can't remember the last time someone called me up about a patient that, you know, went to a different provider.
Q. But if a patient with a Prolift+M seeks treatment outside of this network of three or four docs and doesn't tell you about it for problems with their Prolift+M, you would have no way of knowing about that, correct?

A. I would have no way of knowing about that.
Q. Doesn't it violate HIPAA rules for you doctors to be discussing complications that you've treated with each other's patients if you're referencing those patients by name?
MS. KATZ GERSTEL: Objection.
A. What we do typically is we ask the patient for their permission to contact the implanting physician prior to corresponding.
BY MR. FAES:
Q. So if a patient of yours that was implanted with a Prolift+M by you goes to another doctor for treatment of -- for treatment of a complication with the Prolift+M and doesn't give that other doctor consent to talk to you about it, you would also have no way of knowing about that, correct?
A. That seems de facto, ipso facto, yeah.
MR. FAES: I don't have any further questions for you at this time, Doctor. Thank you for your time.
MS. KATZ GERSTEL: I just have one follow-up.
RECROSS-EXAMINATION

BY MS. KATZ GERSTEL:
Q. Doctor, could you please turn to page 13 of your report?
A. 13.
Q. Do you cite a paper by Barber on page 13 of your report?
A. I did.
Q. And did Barber -- well, strike that.
Are uterosacral suspension and sacrospinous ligament fixation two non-mesh pelvic floor repairs for prolapse?
A. They are.
Q. And did Barber report on exposure rate for sutures after uterosacral ligament suspension and sacrospinous ligament fixation?
A. He did.
Q. And what did he report about suture exposure rates?
MR. FAES: Object to form.
A. So Matt Barber noted a 15.4 percent suture exposure rate after uterosacral suspension, and a 17.2 percent suture exposure rate after sacrospinous fixation.
MS. KATZ GERSTEL: Thank you. That's all

I have.
(The deponent will read and sign.)
(The deposition concluded at 12:35 p.m.)

I, TED ROTH, M.D., do hereby certify that the foregoing testimony taken on March 17, 2017, is true and accurate to the best of my knowledge and belief.

DATE TED ROTH, M.D.

At in said County of , this day of , 2017 personally appeared TED ROTH, M.D., and he made oath to the truth of the foregoing answers by him subscribed.
Before me, , a Notary Public

My Commission Expires:

STATE OF MAINE

I, Lynne M. Morrison, a Notary Public in and for the State of Maine, do hereby certify that pursuant to notice there came before me on March 17, 2017, the following-named person to wit: TED ROTH, M.D., who was duly sworn to testify to the truth and nothing but the truth; that he was thereupon carefully examined upon his oath and his examination reduced to writing under my supervision; that this deposition is a true record of the testimony given by the witness.

I further certify that I am neither attorney nor counsel for, nor related to, nor employed by any of the parties to the action in which this deposition is taken, and further, that I am not a relative or employee of any attorney or counsel employed by the parties hereto, or financially interested in this action.

IN WITNESS WHEREOF, I have hereunto set my hand this 27th day of March, 2017.

Lynne M. Morrison

My Commission Expires:
April 4, 2019

THE ORIGINAL DEPOSITION OF TED ROTH, M.D. SHOULD INCLUDE THE FOLLOWING CORRECTIONS:

Page	Line	Change from this	To this

TED ROTH, M.D.

LAWYER'S NOTES

PAGE	LINE	